

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
	<ol style="list-style-type: none">8. Reimbursement for root canal therapy includes all diagnostic tests, preoperative and postoperative radiographs, preoperative and postoperative treatments, pulpotomy and pulpectomy.9. Reimbursement for a sinus closure will only be made when this service is rendered as a separate procedure and not in conjunction with the removal of a tooth.10. Separate reimbursement will not be made for cavity liners and bases, and office visits, as these procedures are considered to be a component of the appropriate dentally necessary treatment. These services may not be billed to the recipient.11. The provider may bill for emergency treatment (09110) or for the actual dental procedures rendered during an emergency visit, but not for both.12. Gold restorations, gold crowns and gold replacement appliances are not covered services.13. The Program's fee for Procedure Code 00210 (complete series of intra-oral radiographs including bitewings) represents the maximum payable for any combination of periapical X-rays and bitewings.
	<p>TN <u>36-7</u> 12/3/85</p> <p>Supersedes TN _____ Effective date <u>10/1/85</u></p>

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Program

Limitations

B. The Program does not cover the following services:

1. Acrylic jacket crown without a metal superstructure;
2. Porcelain jacket crown without a metal superstructure;
3. Fixed bridge work;
4. Cosmetic procedures;
5. Inpatient hospital dental services rendered during an admission denied by the utilization control agent or during any period that is in excess of the length of stay authorized by the utilization control agent;
6. Services which are investigational or experimental;
7. Local anesthesia as a separate charge;
8. Duplication of dentures;
9. Non-emergency services for non-EPSTD recipients except the following dentally necessary services:
 - a. Rebasing or repairing of dentures;
 - b. Maxillofacial prosthesis associated with traumatic injury and the active or rehabilitative phase of treatment for the removal of neoplasms;
 - c. Non-emergency dental treatment to prevent periodontal problems associated with patients taking phenytoin sodium drug medications.
10. Drugs and supplies dispensed by the dentist which are acquired by the dentist at no cost;
11. Exams as a separate charge;

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PROGRAM (Continued)	LIMITATIONS
10. Dental Services	<p>B. The Program does not cover the following services:</p> <ol style="list-style-type: none">12. Referrals;13. Silicate restorations;14. Diagnostic models as a separate charge except when required for the provision of orthodontic services;15. Office visits;16. House calls;17. Immediate dentures;18. Pre-formed dentures with teeth already mounted, (i.e., teeth already set in acrylic prior to initial impressions);19. Consultant payments when a member of the house staff of a hospital either requests or provides the consultations or, in the case of a group practice, to any partner or associate of that practice who either requests or provides the consultation;20. Aftercare services as a separate charge to a provider or, in the case of a group practice, to any partner or associate of that practice;21. Services when reimbursement is included under another segment of the Program;22. Dentures and service which prepare the month for dentures;23. Unilateral partials replacing less than three teeth excluding third molars.24. Billing time limitations:<ol style="list-style-type: none">a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.

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PROGRAM
(Continued)

LIMITATIONS

10. Dental Services

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b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:

(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.

d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.

e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

Services that Require
Preauthorization

A. Preauthorization is issued when:

1. Program procedures are met;
2. Program limitations are met;

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3. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is necessary and appropriate ("necessary" means directly related to diagnostic; preventative, curative, palliative, or rehabilitative treatment; "appropriate" means an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any service which could be used to the same purpose).

B. Preauthorization is required for the following:

1. Acrylic fused to metal crown;
2. Porcelain fused to metal crown;
3. Non-precious metal crown (full cast);
4. Root canal therapy;
5. Apicoectomy;
6. Subgingival curettage, root planing, periodontal scaling-per visit (except for the first visit for Vincent's Disease or Necrotizing Ulcerative Gingivitis);

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	7. Gingivectomy or gingivoplasty per quadrant;
	8. Complete upper/lower denture;
	9. Partial upper/lower denture (2 clasps each denture);
	10. Each additional clasp with rest;
	11. Any elective surgical procedure not listed on the current Dental Fee Schedule;
	12. Surgery normally considered cosmetic but qualified by traumatic or pathological causation;
	13. Laboratory rebasing of dentures;
	14. Addition of teeth or clasps to a partial denture;
	15. General restorative treatment to be rendered in a hospital;
	16. Special periodontal appliances;
	17. Apexification involving any permanent tooth;
	18. Removal of any teeth, other than under emergency conditions, which would then cause an individual to require a removable prosthetic appliance;
	19. Multiple extractions other than under emergency conditions; and
	20. Occlusal adjustment, periodontal.
	21. Apical curettage;
	22. Root resection;
	23. Overdenture complete;
	24. Overdenture partial;
	25. Condylectomy;
	26. Meniscectomy;
	27. Arthrotomy

Supercodes TM-84-19

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96-7

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LIMITATIONS

28. Certain surgical procedures identified under "Inpatient Services" (Attachment 3.1A, page 12B, number 11) which may be performed by a dentist must be preauthorized when performed on a hospital inpatient basis unless:
- a. The patient is already a hospital inpatient for a medically necessary condition unrelated to the surgical procedure requiring preauthorization, or
 - b. An unrelated procedure which requires hospitalization is being performed simultaneously.
- C. Preauthorization for dental services, except orthodontic treatment services, is valid for eligible recipients when services are approved and are completed within 6 months after the date of receipt of the preauthorization request form by the Program and is contingent on the recipient's continued eligibility.
- D. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program only if authorization for those services has been obtained before billing. Non-Medicare claims require preauthorization according to §§A-B above.

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LIMITATIONS

11. A. Physical Therapy

A. The Physical Therapy Services Program does not cover:

1. Services provided in a facility or by a group where reimbursement for physical therapy is covered by another segment of the Program;
2. Services performed by physical therapy assistants when not under the direct supervision of a physical therapist;
3. Services performed by physical therapy aides;
4. Services rendered to recipients 21 years of age and above; or
5. Services rendered to recipients which are not required to treat a condition detected as a result of a full or partial periodic or interperiodic screen under the EPSDT Program.

B. Billing time limitations

1. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.
2. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:
 - (a) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and
 - (b) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.
3. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.
4. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.

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PROGRAM

(Continued)

LIMITATIONS

11. A. Physical Therapy

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Services that require
Preauthorization

5. ~~Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.~~

A. Preauthorization is required for physical therapy services rendered in excess of 60 days after the first treatment and every 60 days after that.

B. Preauthorization is issued when:

1. Program procedures are met;
2. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is necessary and appropriate ("necessary" means directly related to diagnostic, preventative, curative, palliative, or rehabilitative treatment; "appropriate" means an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of other services which could be used to the same purpose).

C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued.

D. The provider shall verify that the recipient is eligible for Medical Assistance coverage on the date that service is provided, even though preauthorization has been previously issued.

E. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing. Non-Medicare claims require preauthorization according to §§ A-D.

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Program

Limitations

C. Hearing Aid
Services

Listed under Section 4.B (EPSDT) of this
attachment

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